Long Beach Medi-Cal / Healthy Families Outreach Collaborative Participation Agreement Form

1. Participating Collaborative Member Information:

Name_____ Title_____

Organization _____

Address _____

Phone Number_____ext_____ Fax_____

Email _____Website _____

2. Brief Description of Services Provided by Your Agency / Organization:

_____

_____

_____

3. What type of collaborative activities can you or your organization commit to?
(Check all that apply)

- ☐ Distribute fliers and educational materials
- ☐ Host an enrollment event for families
- ☐ Provide refreshments at monthly meetings
- ☐ Present at monthly meetings
- ☐ Assist in planning monthly meetings
- ☐ Sponsor an enrollment event
- ☐ Other_____

4. How would you like to receive our monthly program updates? *(check one)*

☐ **Email** ☐ **Mail or** ☐ **Fax**

Please complete and return to:
Medi-Cal Outreach Program
FAX: (562) 570-8122